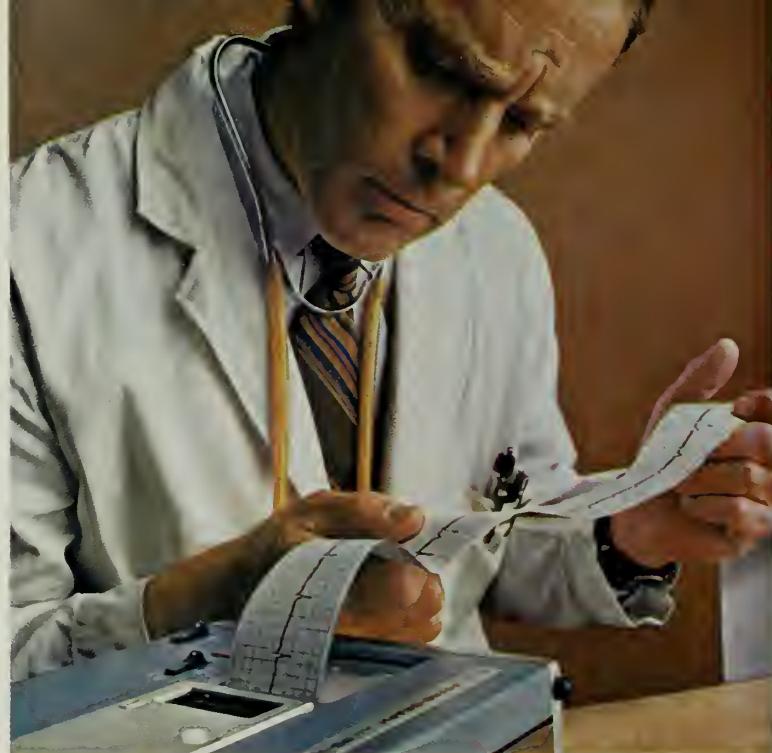


HARVARD
MEDICAL
ALUMNI
BULLETIN

Sept. / Oct. 1973



When cardiac complaints occur in the absence of organic findings, underlying anxiety may be one factor



The influence of anxiety on heart function

Excessive anxiety is one of a combination of factors that may trigger a series of maladaptive functional reactions which can generate further anxiety. Often involved in this vicious circle are some cardiac arrhythmias, paroxysmal supraventricular tachycardia and premature systoles. When these symptoms resemble those associated with actual organic disease, the overanxious patient needs reassurance that they have no

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions

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NAME: _____

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organic basis and that reduction of excessive anxiety and emotional overreaction would be medically beneficial.

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in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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Cover: Although "new" to the medical area,
the lion sculpture actually guarded the en-
trance to 1 Shattuck Street, which was de-
molished in 1970 to construct the new Har-
vard School of Public Health building. Today,
the sculpture is embedded in a wall adjacent
to the Countway Library of Medicine.

Credits: Christopher Morrow, cover and p. 4;
Bradford F. Herzog, pp. 10-11, p. 27.

Overview

Three Grants Aid Education, Research

The Josiah Macy, Jr. Foundation has given a grant of \$198,000 for a three-year period to a joint Boston College School of Nursing-Harvard Medical School program. This unique program is one of the first occasions on which a medical school of one private university has joined forces academically with the nursing school of another private institution.

Announcement of the grant follows the awarding of the Master of Science in Nursing degree to the first eight candidates in the program, in which graduate nurses are educated in close association with Harvard medical students. The new graduates will work in the clinical field in establishments throughout the country and will act as supervisors to the directors regarding future program evaluations and expansions. In addition to teaching as medical clinical specialists, the graduates will form a nucleus for the establishment of similar programs in other areas.

Although inquiries have more than doubled during the past year, the program has been hampered by lack of traineeship money. The Macy grant will provide the resources for the admission of more applicants over the next three years.

The Burroughs Wellcome Fund has given a \$25,000 Special Award in Clinical Pharmacology to Peter Goldman, M.D., professor of clinical pharmacology at HMS. Dr. Goldman will use his award to develop pediatric clinical pharmacology at Children's Hospital Medical Center. In this program, which combines

research and teaching, particular attention will be given to the development of methods for evaluating the benefits and risks of drugs used in pediatric practice. Dr. Goldman is the director of the Clinical Pharmacology Unit which functions at the Beth Israel, Peter Bent Brigham, and Children's hospitals.

Research to Prevent Blindness, Inc. has given an annual grant of \$5,000 in unrestricted funds to support studies of blinding diseases at the Howe Laboratory of Ophthalmology, Massachusetts Eye and Ear Infirmary. The award differs from traditional grants, because it gives maximum freedom to implement research activities for which other funds are not available.

Admission Procedures Attacked by NEGME

Sweeping revisions in medical college admission procedures that would focus on the personal career planning of applicants and on the types of students being sought by individual medical schools, have been recommended by the representatives of the 34 medical schools forming the Northeast Group of Medical Education (NEGME). The recommendations, made to the Association of American Medical Colleges, were included in a position paper presented at a meeting of a Task Force to consider the adoption of a new Medical College Admissions Assessment Program. Robert S. Blacklow '59, associate dean for academic programs at HMS, presented the NEGME report.



Are things so bad you're making change for contributions?

The paper strongly recommended that faculty and staff of medical schools and of undergraduate colleges become involved in the formation of more adequate test procedures for medical school admission.

Emphasis was placed on the development of student self-assessment and career counseling aids to help students make formal and rational career decisions. Additionally, the report stressed the development of publications for career choices in health fields related to medicine, specifically for unsuccessful medical school applicants. Such publications would list and describe those institutions serving particular career fields.

The position paper called for an "open admissions policy" that would make statistics on the entering classes at each medical school available to college seniors. The statistics, by indicating the medical schools' preferences would enable the prospective applicant — in the knowledge of his own academic background and career goals — to decide, in concert with his or her premedical career, whether to apply to a particular school.

The NEGME committee voiced particular concern over the use of aptitude tests and general information tests as a means of evaluating a prospective student's qualification or non-qualification for a medical education.

Data on achievement in the science specific subject areas, science survey areas, and the verbal and quantitative skills are the most important items of data for admissions committee to know. The group questioned the value of a test in physics if the test in fundamental quantitative skills contained problems in physics. Tests in sociology or any of the behavioral sciences should be eliminated from the tests, according to the Group, "because for the time invested, they will not predict performance in the medical school years."

Because the levels of instruction in such sciences as biology and chemistry differ greatly among colleges, the position paper called for the development of multiple versions of tests. Students could then choose a version corresponding most closely to their college course. Results could then be scored and reported in terms of areas of students' strengths and weaknesses.

Finally, the committee recommended that greater attention be paid to criterion sampling and reference mapping. Criterion sampling means that those developing the test must get out of their offices and into the field where they can actually analyze physician performance into its components.

In conclusion, the NEGME paper urged those responsible for the development of a Medical College Admissions Assessment Program to collaborate with the National Board of Medical Examiners in the development of criterion based measures.

Continuing Education Alive and Well at HMS

One hundred years after its founding, the Department of Continuing Education at Harvard Medical School is thriving.

In 1972, the centennial year of the Department, nine new courses were introduced, and this year eleven new courses are being offered, bringing the total to 50. Among the new offerings are Treatment of Allergic Diseases; Radioimmunoassay; Intensive Care of the Critically Ill patient; Modern Genetics Counseling; Acute Respiratory Failure; Pediatric Hematology; Pediatric Nuclear Medicine; and Gastroenterology. All Courses are given at the teaching hospitals associated with the Medical School.



Stephen E. Goldfinger, MD, associate dean, continuing education.

The Department sponsors programs in many diverse areas. Courses cover most of the medical specialties; modern advances of both theoretic and practical import are reviewed along with the fundamental and therapeutic aspects of disease. In addition, the Department collaborates with eight community hospitals in the conception, presentation, and evaluation of programs of continuing education for their staffs. Coordinators from the Department and from the hospi-

tal plan individualized programs of clinical rounds, demonstrations of techniques, lectures, and other sessions appropriate to the practice of the individual hospital. Peer review and medical audit are integral features of many of the programs. Hospitals participating are: Winchester; Burbank (Fitchburg); Anna Jacques (Newburyport); Hunt Memorial (Danvers); Hale (Haverhill); St. Luke's (New Bedford); Cable (Ipswich); and Wing Memorial (Palmer).

Five years ago, the Department organized a program of training in Emergency Room Care at the Massachusetts General Hospital. The curriculum includes approximately 20 hours of seminars on emergency problems in specialty areas of medicine, and about 60 hours of rotation through the emergency ward and other hospital facilities where students observe and participate in patient care activities. They use audio-visual presentations and computer terminal based patient simulation exercises developed by members of the Department.

There is also a 16-week Nurse Practitioner program under the aegis of the Department of Continuing Education and the Massachusetts General Hospital Department of Nursing. Nurses associated with practitioners in the New England area learn the essentials of history-taking and physical diagnosis; the protocol management of selected acute illnesses; and principles of the management of the common chronic diseases. Their supervising physicians cooperate in the design, teaching, and evaluation of the program.

And finally, the Department offers Fellowships in Continuing Education to physicians who have completed two years of residency training. Fellows participate in all activities of the Department and simultaneously obtain advanced clinical training in areas of special interest. They conduct experimental projects in selected areas of continuing education for medical and paramedical personnel. Currently, these projects include the Nurse Practitioner program; the evaluation of quality of care in teaching and community hospitals; the development of computer based programs for teaching and evaluating clinical competence; and the emergency training program.

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Thorndike Memorial Laboratory

The following is the report of the ad hoc Committee to Consider the Future of the Thorndike Memorial Laboratory at the Boston City Hospital.

In January 1973 Mayor White announced his decision to cut the budget of the Boston City Hospital. The Mayor was sympathetic to the needs of the Hospital and supportive of its goal but was forced to this decision because of the great financial difficulties of the City of Boston. In practical terms the budget cut meant a reduction in size of the Hospital to 500 beds and a reduction in the staff, both salaried and professional. The general director of the Hospital, Mr. Guiney, recommended to the Board of Trustees that there be consolidation of the three separate services in medicine, each controlled by a different medical school (Boston University, Harvard, and Tufts) as well as the three separate services in surgery. He further indicated that the administration of the Hospital would be facilitated if one medical school had the responsibility for the professional services at the Boston City Hospital.

Each medical school was asked to submit a proposal to the Board of Trustees outlining the administrative arrangement it would favor. These proposals were reviewed, and on March 1, 1973, the Board of Trustees voted to assign sole responsibility for professional services to Boston University. There were a number of reasons for this decision, and paramount among them were the proximity of Boston University Hospital (across the street) and the potential of shared services with that hospital.

The decision of the Board of Trustees was coupled with an expression of concern for the teaching needs of Tufts and Harvard and the invitation to the two schools to continue to participate in the professional activities of the hospital, including teaching, with the understanding that all administrative decisions in the departments of medicine and surgery would be made by the chiefs designated by Boston University. Despite these expressions of good will, the decision to delegate all administrative responsibility to Boston University had a profound effect on all activities of Tufts and Harvard at the BCH.

Harvard's role in the consolidated department of medicine at the BCH might have been tenable had it not been for two other policy decisions made by Mr. Guiney following the vote of the Board on March 1. Harvard was advised that effective July 1, there would no longer be any identifiable Harvard wards and that no Harvard interns would be selected in the Matching Plan. Harvard residents were invited to remain but with the understanding that they would be a part of the general house staff and that they would be responsible to the Boston University chief of medicine. These actions eliminated the 2d and 4th Medical Services and any Harvard-related house officer program. In consequence, as of July 1, there was no longer a complete Harvard department of medicine at the BCH and the Harvard departments of medicine were reduced to three. (The others remaining are located at the Massachusetts General Hospital, the Beth Israel Hospital, and the Peter Bent Brigham Hospital.)

The total elimination of the Harvard Medical Services at the BCH spelled the eventual dissolution of the Thorndike Memorial Laboratory* at the BCH. There are several reasons for this conclusion and one of these is well-stated by Dr. Franklin H. Epstein, the present director of the Thorndike and head of the now defunct 2d and 4th Medical Services. He wrote: "The great strength of the Thorndike has been the interplay, the traffic, between highly selected house officers and physicians of the investigative laboratory. If the Thorndike were to try to exist as an independent research unit, free standing and bereft of the reserve bank of bright, young men and women that have sustained its growth, it would be weakened almost at once." There is a second closely related reason: The

*The phrase, "Thorndike Memorial Laboratory," used here and subsequently in the text, as well as the word, "Thorndike," refers to Harvard's activities in the Laboratory and the support of these activities through Harvard endowments, and not to the actual laboratory at the BCH.

absence of a Harvard medical service makes the Thorndike less attractive to junior faculty and will increase the natural attrition which has always occurred and indeed has been encouraged. For the same reason it will be more difficult to recruit new junior faculty.

The decision of the Board of Trustees was publicly announced, and it was common knowledge that the long-term future of the Thorndike at the BCH was untenable. It was natural, therefore, that a number of offers for relocation of the Thorndike should be made by other hospitals associated with Harvard. Specifically, the Beth Israel Hospital, the Peter Bent Brigham Hospital, and the Mount Auburn Hospital indicated to the Dean of the Faculty of Medicine their willingness to house the Thorndike. The Dean concluded that a decision of such great importance should be made in a formal fashion, and only after the most careful deliberation, and therefore asked the President of the University to chair an ad hoc committee which would recommend to him what action should be taken. The members of the ad hoc committee were President Derek C. Bok, chairman; Dean Ebert; Dr. Robert H. Williams (Seattle) and Lewis Thomas '37 (New York), both former members of the Thorndike staff; and Dr. Baruj Benacerraf, head of the department of pathology at Harvard.

Procedure

In preparation for the meeting of the ad hoc committee July 24, 1973, a number of documents were submitted to the members of the committee. In May 1973 a detailed report was submitted to the Dean by a committee of junior and senior members of the Thorndike Laboratory chaired by Dr. Walter H. Abelmann, professor of medicine, BCH. This report not only made general recommendations but also presented a wide range of factual information about the Thorndike, and copies of the report were sent to the members of the President's ad hoc committee. In addition, the Beth Israel, Mount Auburn, and Peter Bent Brigham hospitals submitted proposals for housing the Thorndike, and Maxwell Finland '26 submitted a detailed memorandum to the committee. The proposals can be summarized as follows:

The Beth Israel Hospital. In a letter of intent from that hospital, it was stated that the Beth Israel is committed to academic medicine and could provide both the intellectual and physical environments to house the activities of the Thorndike. The Trustees voted to construct an additional floor of the Slosberg-Landay Building with a net floor area of between 10,000-20,000 square feet for the Thorndike as well as a clinical center with an associated core laboratory. The Trustees further indicated their willingness to provide additional space for the activities of the Channing Laboratory. The Trustees have indicated their willingness to increase substantially the financial support of the department of medicine regardless of the decision about the Thorndike. The proposal stated that two-thirds of the need for additional teaching beds in medicine to replace those lost at the BCH will be met by new construction at the Beth Israel. The argument was made that the move of the activities of the Thorndike (and possibly the Channing) to the Beth Israel would place these laboratories within walking distance of the basic science resources of the Longwood Quadrangle. Finally, it was argued that the relocation of the Thorndike at the Beth Israel would assure three powerful divisions of the department of medicine rather than only two.

The Mount Auburn Hospital. This proposal offered to make available for the Thorndike Laboratory shell space on the 4th and 5th floors of the newly constructed Central Building and at a subsequent date to provide a site for a new laboratory building. It was argued that the relocation of the Thorndike at the Mount Auburn would strengthen the teaching capacity of the hospital and would in effect make up for the loss of teaching beds at the BCH. Mount Auburn is a community hospital as well as a teaching hospital, and the proposal emphasized the importance for the Medical School to have a closer relationship with a community hospital which offers a different type of training to medical students than Harvard's teaching hospitals in Boston. The wisdom of placing a great clinical research facility in proximity to the science departments at Harvard and the Massachusetts Institute of Technology was argued. The proposal made it clear that the invitation to the Thorndike

was a cordial one but that the hospital could not finance the completion of shell space or the cost of a new building. These costs would have to be assumed by Harvard.

The Peter Bent Brigham Hospital. In the letter from the Peter Bent Brigham Hospital, it was noted that the present staff of the Thorndike would complement well the staff at the PBBH but that it was desirable to maintain the cohesiveness and identity of the Thorndike staff. It was proposed, therefore, that specific space would be assigned to the Thorndike staff in the virtually completed research building being constructed for the department of medicine and that the building would be named the Thorndike Memorial Laboratory. The letter went on to say

that space for future expansion will exist after the Affiliated Hospitals Center is built and that the PBBH is willing to commit substantial salary and research support to insure the long-term stability of the Laboratory. It was proposed that the clinical research beds presently at the Thorndike could be added to the PBBH Clinical Research Center. The argument was made that the proximity of the PBBH to the basic science departments on the Quadrangle would foster interaction between basic scientists and clinical investigators. Finally, it was argued that because of the current difficulties in funding medical research, it might be good strategy for the Medical School to concentrate its clinical academic activities in a few areas rather than disperse its resources.

The Thorndike



Dr. Finland's memorandum argued that it was unwise to disperse Harvard's clinical activities at the BCH and that consideration should be given to a relocation of Harvard's entire operation at the BCH to another center. He proposed that this center should be in Cambridge and that it would be possible to build entirely new resources for teaching, research, and patient care if all of Harvard's resources at the BCH were kept intact. He noted that these resources could provide an academic focus for important medical activities in Cambridge, including those at the Mount Auburn, the Cambridge Hospital, the Harvard Health Services, the M I T Health Services as well as some community clinic and centers. He suggested that if this approach were accepted in principle by Harvard University, M I T, Harvard Medical School, and the Mount Auburn Hospital, the details of physical structure, staffing, financing, and administration could be worked out. He urged, therefore, that no separate decision be made concerning the relocation of the Thorndike and that instead a task force be established representing a wide variety of interests in order to determine the best site for the relocation of Harvard's activities at the BCH. He further recommended the creation of another committee to examine the feasibility of fund raising for the new enterprise.

The ad hoc committee met July 24, 1973 and first heard from the following witnesses:

Maxwell Finland '26, George Richards Minot Professor of Medicine, *Emeritus*, and former director of the Thorndike.

Herbert Benson '61, assistant professor of medicine and Clyde S. Crumpacker, II '65, instructor in medicine, both junior staff members from the Thorndike.

Franklin H. Epstein, professor of medicine and director of the Thorndike Memorial Laboratory.

Representatives from the Beth Israel Hospital, including Mitchell T. Rabkin '55, general director; and Mr. Sidney Stoneman, chairman of the Board of Trustees.

Representatives from the Mount Auburn Hospital including Mr. Walter P. Allen, executive director; Mr. Casimir de-Rham, chairman of the Board of Trustees; and Dr. Ronald A. Arky, professor and chief of the division of medicine.

Representatives from the Peter Bent Brigham Hospital, including Dr. William E. Hassan, Jr., director; Mr. F. Stanton Deland, president of the board of the Affiliated Hospitals Center; and Dr. Eugene Braunwald, Hersey Professor of the Theory and Practice of Physic and physician-in-chief.

Dr. Edward H. Kass, professor of medicine and director of the Channing Laboratory of the Boston City Hospital.

The ad hoc committee then met to consider the evidence and arrived at a unanimous decision. The remainder of this report deals with the issues as viewed by the committee.

The preservation of the identity of the Thorndike was repeatedly stressed in both written documents and in the evidence presented by witnesses. As this concept was pursued in questioning of witnesses, it became evident that "identity" meant much more than a physical facility or even the preservation of the present group of investigators. It really meant more a philosophy or an approach to medicine, and it centered around the juxtaposition of caring for patients, teaching and clinical investigation. It was uniformly held that the Thorndike could not exist as a separate research institute and that its success in the past was linked to its intimate association with the 2d and 4th Medical Services at the BCH. In other words, the Thorndike would lose its identity unless it had clinical investigators who were

View from the roof of BCH.



also concerned with problems of general patient care, fellows with the same interests, a laboratory facility which included a clinical investigative unit, a clinical service staffed by the same faculty and a strong teaching program for both medical students and house staff.

Discussion of "identity" led naturally to questions about the total environment needed for the Thorndike Memorial Laboratory, and all of the witnesses presently associated with the Laboratory said that academic hospital departments in the other medical disciplines were essential. An academic department of medicine could not flourish in isolation and needed the support of academic departments of surgery, pathology, radiology, etc. In summary, the Thorndike required the environment of a full-scale teaching hospital.

Another consideration of the ad hoc committee was the most appropriate disposition of Harvard's resources at this particular point in time. Should Harvard attempt to create a new major teaching hospital to replace the Harvard services at the BCH, or should it attempt to consolidate what it has? In the opinion of members of the committee, the prospects for federal funding of teaching hospitals remains bleak, and fund raising in the private sector is highly competitive, particularly in Boston because of the multiplicity of teaching hospitals. For these reasons it was felt that consolidation was more prudent than expansion. There was cognizance of the need for teaching beds, but it was emphasized that the limiting factor was the size of the clinical teaching staff and not the actual number of beds. A further consideration was timing. All of the present members of the Thorndike unit stressed the need for a decision — and that the Laboratory would rapidly disintegrate if no decision were reached.

Finally, the ad hoc committee was sensitive to both the needs of the communities served by the three hospitals and the potential reaction of these communities to the relocation of the Thorndike. It was felt that the move of the Thorndike to either the Peter Bent Brigham or the Beth Israel would have relatively little impact, since it would not change the fundamental character of either hospital. It might, however, have a much greater impact on the Cambridge community.

The committee had two fundamental choices: to move the Thorndike to Cambridge and expand Harvard's commitments, or to locate the Laboratory at the Beth Israel or Peter Bent Brigham and consolidate its resources. Therefore, the first consideration was the relocation of the Thorndike at the Mount Auburn.

On the basis of the considerations noted earlier, it was evident to the committee that the move of the Thorndike to the Mount Auburn implied a much greater commitment on the part of both the University and the Hospital than the simple transfer of the present staff and Laboratory. It meant the evolution of a full-scale teaching hospital. The Board of Trustees of the Mount Auburn, together with the medical staff, had indicated their strong support for the move of the Thorndike but had not had the opportunity to consider the full implications of a complete change in the character of the Hospital. It is unclear that such a change would be greeted with enthusiasm by the staff, and it is equally unclear that the Cambridge community would welcome a full-scale university hospital in place of an excellent community hospital with strong university ties. Recent experience would suggest that communities do not strongly support teaching hospitals and, indeed, may exhibit quite negative feelings about them.

The committee gave serious consideration to the proposal made by Dr. Finland that no decision be made until a feasibility study could be done of the relocation of the total Harvard operation at the BCH to Cambridge. It decided, however, that this was impractical for the following reasons: First, it was repeatedly stated by present members of the Thorndike staff that some decision needed to be made in the near future to prevent rapid dispersion of young staff members. The study proposed by Dr. Finland would be time-consuming and the delay would make it difficult to maintain the Thorndike operation. Second, it was unclear to the committee how it would be possible to transfer all of Harvard's activities to either the Mount Auburn or Cambridge Hospital without totally changing the character of either hospital. Third, it was not clear that the scientific resources in Cambridge, rich as they are, would necessarily have any great impact on a new teaching hospital on the Cambridge

side of the river. It seemed more likely that the proximity of the Quadrangle basic science departments to the Thorndike would enhance opportunities for interaction between basic scientists and clinical investigators. Finally, the committee was skeptical that the necessary financial resources could be found to implement the major relocation proposed by Dr. Finland. The committee decided, therefore, that it could not decide in favor of the Mount Auburn proposal or the recommendations made by Dr. Finland.

There remained the choice between the Beth Israel Hospital and the Peter Bent Brigham. Both could provide the appropriate environment; both hospitals expressed concern for the identity of the Thorndike; both were prepared to finance the cost of new laboratory facilities; both were prepared to expand their teaching commitments. Since there was so little difference in what could be offered by the two hospitals, even minor considerations became important. Two factors tipped the scales in favor of the Beth Israel.

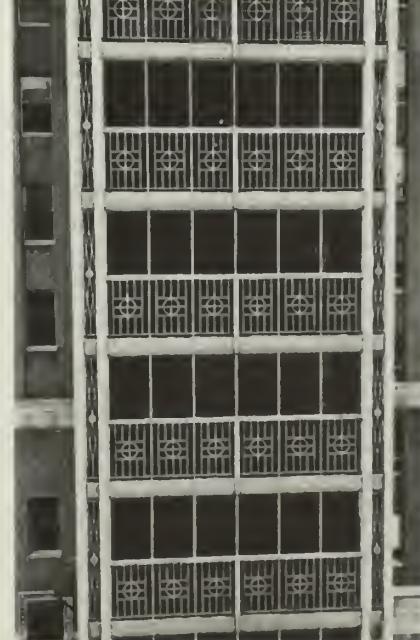
First, Dr. Frank Epstein, the present director of the Thorndike, has recently moved to the Beth Israel as head of the department of medicine.* His presence will aid in the transfer of the activities of the Thorndike to the Beth Israel from the BCH, since he is so familiar with the

staff. The Beth Israel does not have a clinical research center, as does the Peter Bent Brigham, and the ultimate transfer of that unit would be facilitated, since Dr. Epstein is currently the Principal Investigator of the Clinical Research Center at the Thorndike. In addition, Dr. Epstein has performed extremely well in his brief tenure as director of the Thorndike and his continued leadership promises to maintain high morale and successful performance.

Second, a move to the Beth Israel seems more likely to benefit the balanced growth of the Harvard-affiliated hospitals and to serve the long-run interests of the Medical School. The Peter Bent Brigham, Robert Breck Brigham, and Boston Hospital for Women have agreed to merge, provided a certificate of need can be obtained to authorize the building of a new hospital called the Affiliated Hospitals Center, Inc. This will consolidate the strengths of these three hospitals and, with the addition of the Robert Breck Brigham, will add to the resources of the Peter Bent Brigham Department of Medicine. A gift from the Seeley G. Mudd Fund to Harvard will be used to build a new research building which will provide a significant amount of research space for the Affiliated Hospitals Center. In the opinion of the committee, these actions will substantially assist the department of medicine at the Peter Bent Brigham Hospital (to become the Affiliated Hospitals Center). On the other hand, the department of medicine at the Beth Israel needs to be strengthened. Since the committee felt that three strong departments were desirable for the Medical School, it concluded that a better balance would be maintained if the Thorndike were relocated at the Beth Israel Hospital rather than the Peter Bent Brigham.

For all of these reasons it was the unanimous decision of the ad hoc committee that the wisest disposition of the activities of the Thorndike Memorial Laboratory was to relocate them at the Beth Israel Hospital.

Delicate pattern of BCH building.



*Dr. Epstein has also been named the Herman Ludwig Blumgart Professor of Medicine, and physician-in-chief at the Beth Israel Hospital.

Health Care and Its Finance

by Thomas D. Cabot

Now that I have survived the flak aimed at my views in health care as exposed in an article for lay readers in the *Bulletin* for alumni of Harvard in Cambridge, I am encouraged to write a supplement for the medical profession. I hope my views will be considered friendly by the professionals for I am a grateful patient whose life has been prolonged to an overripe age by the skills of Harvard physicians.

My theme is that if the financing of unlimited health care is made universally available before we improve the delivery system, there will be such an acceleration in the rising costs that a discontented public will deprive the doctors of some of their traditional freedoms.

In my previous article I have suggested that we will not be able to afford a system of health care which puts us in the forefront among the nations in the health of our people unless we first:

Pay each practitioner a salary based on competence appraised by his colleagues in group practice.

Charge each consumer an annual fee for keeping him well and treating his ills.

Abolish torts for malpractice and substitute a fixed schedule for avoidable mistakes that are certified by an appointed board.

Use economic sanctions to force each person to have a fixed point of entry into the health care system, so that primary care in all but a true emergency can be given by a person especially trained for such responsibility.

Restrict new facilities to those conforming with a worthy regional plan.

The right to medical protection has become almost as widely accepted as the right to a basic education. Nevertheless the distribution of care is uneven. At present more than 10 percent of our population — mostly poor, nonwhite, unemployed and self-employed — have no medical coverage. Many bills have been introduced to extend the coverage, but the debate focuses more on the source of funds than on how to spend

them. Would it not be more orderly to decide what portion of our Gross National Product we can afford for health care and how we can spend it most effectively before we debate the form of health insurance or tax support needed to bring care to the disadvantaged?

Already we are allocating nearly 8 percent of our GNP to health and this share is rising. Clearly we must find the kind of incentives for cost effectiveness in the health field that American industrial leadership has devised for other segments of the economy. Otherwise we are unlikely to keep costs within such limits as the nation can readily afford.

We spend more of our income on health care than other industrial nations but lag in health statistics. Even if not strictly comparable, the World Health Organization figures on survival cannot be ignored. Although health is subject to many factors other than care, it is the doctors that are blamed for deficiencies. Our doctors are the best trained and our hospitals are the world's most costly. We are spending millions on education, research, and new facilities. Most of this expenditure is oriented toward sickness, which is only one component in health. Perhaps if we paid the providers not just for curing the sick but for keeping us well they might take a greater interest in such other health factors as personal hygiene, diet, bad habits, accidents, environment, and law enforcement.

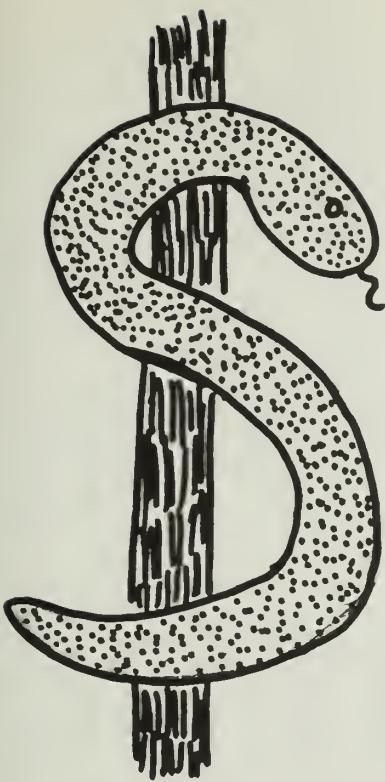
Surely a system that pays providers for keeping us healthy makes more sense than one that makes piecemeal payments related to sickness. The greatest fault of the traditional piecework fee-for-service system of payment is that the buyer has no basis for judging what he needs. How can a sick patient decide what tests or therapies he should have? Quite rightly a doctor must insist that no other party should interfere in his decisions as to his treatment of his patient. As a mechanism for controlling an economic system, the discipline of the

market place serves pretty well where the buyer is free to decide what he wants and what he is willing to pay, but in a piecework system where the seller makes the decisions there is no control except the seller's conscience.

The decisions that doctors must make are far more important to their clients than the decisions of others who serve us in a position of trust. Rules against conflict of interest govern the decisions of others. Such an obvious conflict of interest as the fee-for-service system would not be tolerated in the management of funds. It is not reasonable to predict that the kind of restraints which have been put on those whom we entrust with our wealth are likely to be applied to those whom we entrust with our health?

The primary problem is to find cost incentives without impairing the quality of health care. As an industrialist I am inclined to think first of monetary incentives but doctors are motivated by other considerations to a far greater extent than those who work in the business world. In fact at the Markle sponsored symposium at Williamsburg in 1969 on motivations in medicine there was hardly a word about economic motivation.

It can be argued that a fee-for-service system is an incentive to the doctor to perform unpleasant services such as emergency calls at night. There does not seem to be much evidence that many doctors are so insensitive as to need that stimulus. If professional pride, the Hippocratic tradition, and the dedication to human welfare that impels men to enter the profession are insufficient incentives, it is possible to augment a salary with special bonuses to cover unusual services. Also, it can be argued that the threat of malpractice suits inhibits negligence. I am not persuaded that litigious patients get better treatment and my experience with hospitals and insurance companies convinces me that only a small fraction of the true cost of the malpractice suit threat ever gets paid to honest victims of malpractice. Nor is it likely that allocating a larger share of GNP to the present system will improve the quality of care, for the system is likely to be seriously strained by overloading.



The reforms I have suggested are to a large extent inherent in the HMOs and it is the growth of these by voluntary choice that offers the best insurance against legislation which will regiment the profession. As long ago as the Flexner Report it was suggested that a full-time salary for doctors would remove the economic motive to over-prescribe. Enough evidence has now accumulated to predict a saving in these HMOs of a third of the cost with no impairment of quality as compared with the traditional system. Nor is there an impairment of the physician's net income if we make allowance for fringe benefits. The saving comes largely from reducing the number of operations and therapies which are of doubtful value, and tests which are irrelevant to symptoms. Admissions to hospitals of patients who can as well be treated as out-patients is another important factor. Working in an HMO with a close hospital affiliation, a doctor's decision on the treatment of his patient is freed from the effect on his own income, and he is under less pressure from administrators and colleagues to keep the beds filled and the facilities busy.

Opponents of HMOs will argue that they lead to cutting corners as well as costs. There is little evidence in overall statistics to support this view. Several studies indicate that health records actually improve when doctors are paid an annual

fee to keep clients well. Health being too amorphous for an exact definition, it is easy to quarrel with these conclusions but they are the findings of the National Advisory Commission on Health Manpower in 1965 and the trend since then has been favorable to the HMOs. That Commission's report on the Kaiser-Permanente Program attributed its relative economy not so much to deviations from standard medical procedures as to reduction in hospitalization when not medically justified. It found that despite efforts to improve organization and budgetary controls, Kaiser-Permanente had not been able to do much about costs per unit of service, but that it had shown a marked success in reducing the number of units required per person. Restricting medical services in general, and hospital care in particular, to medically justified situations was found to be responsible for most of the saving.

More recent testimony to the effectiveness of the HMOs in controlling costs can be found in the studies of Drs. Herman M. and Anne R. Somers and especially in her report of the Commonwealth Fund symposium published by the Fund in 1971, in the studies of Lester B. and Judith R. Lane of Carnegie-Mellon University and especially their persuasive paper delivered at the Duke University symposium on health care in 1970, in the study by Greer Williams of Tufts Uni-

versity sponsored by the Kaiser Foundation, in the report of the American Assembly symposium at Arden House in April 1970, in the paper by John R. Knowles on Medical Manpower delivered at the London conference of the Royal Society of Medicine in April 1971, and in articles by J. D. Ratcliffe in *Reader's Digest* for April 1972, by E. K. Faltermeyer and by M. B. Rothfeld in *Fortune* for January 1970 and April 1973 and by the editors of *Forbes* in March 1973.

Recently the Committee for Economic Development has issued a report by a prestigious group of businessmen and educators calling for a major overhaul of the nation's health care systems. Its support of the HMO principle is well argued with much data to back up its conclusions. Various labor organizations have also argued in favor of the HMOs. More important has been the sponsorship of President Nixon and of former Secretary Richardson. The movement seems destined to grow, but the real question is whether and to what extent voluntary reforms of the health care system will satisfy the rising tide of expectations of the general public. Let us hope that this tide does no serious harm to those freedoms which the medical profession must have if it is to preserve the traditions of dedicated service which we honor.

Commentary

by Claude E. Welch '32

The recommendations by Mr. Cabot merit the attention of all physicians and the public. He speaks with authority of principles that have been tested in industry and business. Yet, perhaps unconsciously, his conclusions are based on his own personal characteristics — unbounded energy and intense enthusiasm for any task he undertakes. Few men have given so much of their spare time to the Harvard medical community or have at heart so much respect for the medical profession. Though his criticisms may not be acceptable to many doctors, it must be recognized that they are developed to help a floundering profession rather than as an expression of rancor.

At the outset two fundamental questions must be proposed. Do the members of the profession have the same altruism and capacity for work that he by nature takes for granted, or are many of us a little more often than we would like to admit essentially a little lazy and in need of prodding to give our best? How can we serve the public with better delivery of health care while the profession remains happy as well as productive in the face of overwhelming demands?

A discussion of all the important points he has raised in his article would require a volume. Consequently, these comments will be restricted to the five essential features of health care that he out-

lined in his third paragraph. His principles will be rearranged, progressing from those in which there is, to my mind at least, complete agreement, to those that are controversial.

1. Abolish torts for malpractice and establish boards for adjudication of claims. Every doctor will agree that the thrust of malpractice suits is a dangerous threat. It makes every patient a potential adversary rather than a partner in the eradication of his disease. It is extremely costly for the doctor and therefore for the public. The report of the Federal Commission on Malpractice, if anything, has aggravated an already explosive situation. For example, nearly all of their recommendations urge the medical profession to change its ways; essentially no mention is made of prospective changes in legal practice, such as abolition of the contingency fee that is considered either barbaric or immoral in such countries as Great Britain and New Zealand. If the public would clamor for the principle that Mr Cabot advocates, just as it finally did for no-fault automobile insurance, it would reduce the cost of medical care in this country by an amount that has been estimated to be as high as \$500,000,000 yearly.

2. Conformity of new facilities with a regional plan. All the doctors who have observed the various echelons of medical care in the Armed Forces have noted a smooth transfer of patients with complicated problems to larger centers and recognize the importance of such regional planning. The medical profession has urged regional planning but insists that practicing physicians be represented on these boards.

Yet there are other associated problems. Many planning activities turn out to be useless gabfests and good plans can be vetoed; the slow progress of the Harvard affiliated hospitals is one example that strikes close to home.

There is indeed some doubt about the legality of their power. For example, is there anything in the U.S. Constitution that would prevent the establishment of a new hospital even if a planning board denied approval? If such a hospital could deliver services to the public in a more economical fashion, it should be allowed to exist. Thus planning boards could become regressive rather than progressive. This issue of free enter-

prise in the medical market place almost surely will be submitted to the Supreme Court in the near future.

3. Capitation fees designed to keep people well and to treat their ills. The title "Health Maintenance Organizations" has an appealing charisma but it certainly is not as bright in Washington as it was a few months ago. What does it mean in practice? To keep people well, physicians may advise regular exercise, weight control, elimination of alcohol, tobacco, even coffee, but not even Volstead or an amendment to the U.S. Constitution could force compliance. Much prevention of modern disease devolves directly on the public. To make the profession financially responsible for environmental and personal disasters of the public that individuals refuse to correct, erroneously inflates the costs of physicians' care; these items should be charged elsewhere in the nation's ledger. On the other hand, capitation fees for treatment of ills are palatable and acceptable to many in the profession and can serve as an alternative method for payment of medical care.

4. Fixed entry into the health system with appropriate care by specialists. There are two important considerations included in this recommendation. With the second — care by specialists in all but true emergencies — there can be no quarrel. Group practice is growing rapidly in this country so that referral to the proper specialists becomes progressively more simple. Distribution of specialists is a continuing problem but should be aided by suggestions emerging soon from the study of surgical services in the U.S. now being completed by the American Surgical Society and the American College of Surgeons.

But the suggestion that a fixed entry point into the health system be required is a bit indigestible. Is a patient who believes he has acute appendicitis obligated to call a nurse who directs the triage center to tell him what to do? Perhaps he would much rather directly call his good friend who is a surgeon and lives next door. Multiple voluntary points of entry would seem much more desirable, with each general practitioner or specialist serving as a primary physician or as a director of traffic. This recommendation was made in 1967 in the Millis Report and seems a much easier way to obtain entry.

5. Pay each practitioner a salary based on peer determinations. Fee-for-service, a concept vigorously supported by the medical profession, would be eliminated. Mr. Cabot believes that cost incentives are not important to doctors. However, I am certain that there is no more sensitive topic in the whole domain of medicine than the finances of physicians — whether they are solo practitioners, in a group, or professors in the whitest of the ivory towers.

It is imperative that incentives be built into any system of delivery. Fee-for-services has a built-in incentive; the harder a person works the more he receives. There may be built-in incentives with salaries but they are likely to be absent and certainly much less obvious. There is a great deal of evidence that fee-for-service will promote more service for the public and happiness for the doctor than the payments of salaries that will be characterized by increased fringe benefits and shortened hours of practice. Over-utilization has been emphasized as an accompanying evil of fee-for-service; I believe it is less dangerous to the public than the under-utilization that certainly occurs with universal salaried arrangements.

It should be noted that some doctors are much happier to work under one system and some under the other. A choice of methods of payment would seem to be the best solution. Our country should support both fee-for-service and payments by salary.

In conclusion it should be noted that many of the features of Mr. Cabot's design are incorporated in the present system of medical care in Sweden. Depersonalization of care, essentially equivalent salaries for all medical personnel from the resident to the specialist, assumption of essentially all costs by the state, and regional planning are features of their system. If the Seven Crowns Reform succeeds in Sweden it might succeed here; if it fails there it will certainly fail here. This is an experiment that we all must watch with great care. Meanwhile, let our national experiments continue as pilot projects and maintain options both for the profession and the public.

Mr. Cabot is a member of three Visiting Committees for Harvard University; Dr. Welch is president of the HMAA.



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The Tunnel

by James A. FitzGerald '43A

The week comes to Saturday: three p.m.; he is at home, alone, in bed. In residence because he has the duty and there is no other place to go, solitary because his family is vacationing at the river; he is bed-tired from traversing the tunnel of the day, the week, the month, the year.

One hour before he had finished a surgical schedule begun at eight a.m.; in the days of this week he had seen a host of patients in his office, had operated on alternate days, and had delivered only five babies. The paucity of births was neither an echo of the tenor of the times, nor was it attributable to the Pill or the intra-uterine device, nor was the practice small — it was enormous; as he became older, the deliveries were a duty largely carried out by his associates.

Lying down, he is weighted by the multiplication of days by seven to make weeks, by thirty to make months, three hundred and sixty five by fifty to make years.

He sleeps in an orderly, disorderly room. Today it has had no housekeeping; the bed is unmade, the linen creased, the pillow confounded. There are scattered, unhung trousers, soiled shirts. The disorder is central; and over, under, and beyond the periphery of the bed with its scattered items is the even continuum of the blue floor, the white walls, and the echo-free ceiling.

The sliding doors of the garment closet are closed, the grinning apertures in the drawers of the build-in dresser rise to an alcove containing knicknacks and baby pictures. The rosewood desk has its cubby holes scuffed with papers. The perpendicular, seven-foot bookcase has its volumes neatly inserted.

The order is interrupted by the low table at the windows, crowded with journals and papers; outside there are leaning peonies and vertical gladioli at the front door entrance.

The front lawn pines and the more distant elm and maple, together with the green perimeter of the hills, indenting the sky — reestablishes the symmetry.

Exhausted, he sees none of this. The fatigue shutters the eye and wraps the mind in an almost impenetrable cocoon. It etches on facial lines, peaks the greying face, and even in the rubicund creates a pallor. It co-exists with an inertia that makes breathing, sighing, walking, a Herculean task. Only by sleeping with a mind at ease, is it relieved; it is required that the sleep be uninterrupted. Lying naked except for shorts, he is like some vulnerable, sacrificial offering.

Five miles away, rhythmic stirrings, originating in a finality of multiplication, begin in the uterus of Agnes B. She is a tall gypsy-like girl who easily adds the total of her years to nineteen, and with more difficulty, the lunar months to ten. Her complexion and eyes are clear, a physical characteristic found in women with whom a pregnancy is in physiological agreement. She is complacent, a freshman in education in Canton, single, at term.

At six p.m. her contractions are at two to three minute intervals; there is back-ache, pelvic pressure, a mucoid vaginal discharge.

On the fourth ring of Dr. Jackson's phone, he is awake. His response is Pavlovian; clutching the phone in his left hand, intruding it into his mind, he is half erect at the edge of the bed.

"Hello."

"Dr. Jackson?"

"Yes."

"This is Agnes B. I am having regular pains."

"Are you uncomfortable?"

"Yes."

"You should go to the hospital."

With the girl's name, his mind completes the summation; primipara, frank breech, borderline pelvis confirmed by X-ray.

From the interrupted sleep, nausea, slight reverse peristaltic contractions in his stomach, is added to his fatigue. Stumbling a little, he is in the adjacent bathroom retching a small quantity of material. His face bathed, he puts on the scrub suit hanging on the bathroom door, socks and shoes, and finally, a jacket.

Sighing and moaning, he mutters profanely. The diatribe is all inclusive; birth, life, and death. Driving, he arrives at the hospital entrance. The corridor to the elevator is long, the atmosphere dry, acrid, and hostile. Two floors up he leaves the elevator, passes the window, and enters the labor room.

He is grim and his greeting to the nurse is curt. Agnes B. is in bed, the edges of its sheets are neatly folded, the pillow precise; she is half naked in a hospital gown. They greet each other and he repeats the pertinent questions.

"When did you eat last?"

"At breakfast."

"Respiratory infections?"

"No."

"Is the baby active?"

"Yes."

"Unusual bleeding?"

"No."

A

The plastic glove on, he examines the patient. Agnes B. is supine, legs spread-eagled; the exploring fingers lubricated by the antiseptic liquid and the froth of the patient's vaginal discharge, travel to the cervical opening (two fingers dilated). Probing the lateral pelvic walls and her belly confirms that the baby is still breech with both legs flexed along side of the abdomen. The breech is still high in the pelvis, no umbilical cord has prolapsed, the membranes are intact, the fetal heart is normal. He reminds the patient that if she does not make satisfactory progress in labor, a Caesarian section may be necessary.

He is more composed than before — but uneasy; the fatigue is present but diminished; the gastric stirrings still active. He writes orders for medication for the patient, sips some water which augments his pains, and tells the delivery room nurse he will be at home.

With the one and two of things, with the alpha and beta of things, Agnes B. is reassured. She is apprehensive, but sustained by the presence of the doctor and nurses. The flow of the enema increases her contractions.

He returns home. He feels more secure there. He is away from the trial, and subject only to the thrust of responsibility and the invasion of the phone.

The house is dark and quiet and he would have some ease except for the intermittent pains in his stomach. He has not eaten since breakfast and is not hungry. He drowses but does not sleep. Three times the phone rings: the first query concerns the hazards of omitted contraceptive pills; the second a plea for an ointment to relieve dyspareunia; and to the third call, he provides questionable reassurance for a menstrual period one week late. He muses bitterly that the world is a womb with all the consequences thereof.

Four a.m. Sunday: he has slept, restlessly and not well. Aroused by the phone, he is informed that Agnes B. is "pushing." He lingers, queasy. The cocoon is thicker, the shroud envelopes the eye, the ear, the tongue, the gait. It is encompassing, limiting, dark inside; he is moistened by perspiration and the rhythm of the cramps begin again. He delays to evacuate a diarrheal stool, and dressed again, is en route to the hospital.

It is hotter there, drier. The light over the emergency room is out and the corridor in the distance is dim. He follows the cavern to the further confines of the elevator and passes through two levels to the maternity floor. The walls converge to the labor room.

It is dimmer and noisier here than before. With each contraction, Agnes B. screams. The lesser rays of the gooseneck lamp halo the deliquescent hair and face, the writhing countenance, the tumescent abdomen. The stronger rays bathe the engorged perineum flecked with moisture and meconium. Her anus gapes and with each contraction there is a tiny torrent of fecal material. The bed is a disorder: soiled, the folded angles of the sheets are askew, the moist pillow changing shape with the tossing head.

The lubricated glove meets the fetal buttocks and scrotum; the mouth of the womb is non-existent. There is a penis and, as inverse as is the disorder in things, it is extruded with each contraction.

The shroud is in the delivery room, the curtains shuttered. Scrubbing, he is not absolved by his ablutions, and masked and gowned, he stands compressed by the electrically heated bassinet, the instruments tray, the table with the paper drapes. The delivery room table is austere, sheets crisp and folded, no pillow. The walls of the room are blue-tiled to half the distance, and then white to acoustical dullness.

She is asleep; Penthane, legs again spread-eagled, but in stirrups. He paints the lower abdomen as mad as any mural, he tinctures the perineum, the thighs, the vulva, with the lipstick red of Zephyran. She is draped; to facilitate entrance and emergence, he divides the perineum. Allowed access, he titillates each posterior knee, till flexing, the infant's lower extremities become available to his grasp. On these he pulls urgently, directing the back to a dorsal position. The arms he frees from their position of salutation to parade dress. His forceps embrace the fetal head. He is gentle, artful, he has travelled this route many times before, and in the alpha and omega of the process, he is entirely preoccupied. The forceps guide through inlet, mid-pelvis, introitus; and limp, gray, mottled, face forceps lined, the child is born. The machinery of respiration, quickly established, suffuses; the child loses its harlequin coloring and cries.

Dr. Jackson completes the amenities; cord divided and tied, after birth removed, perineum repaired. His cap, mask and gown are deposited with the blood-stained drapes at the foot of the delivery table; and in the center, the sacrifice completed, is the naked Agnes B. white and sleeping. The child, eyes closed, breathes pale and quiet.

He is in the adjacent doctor's room; its bunks double-tiered, the sheets prim, pillows nicely positioned, and for warmth there are folded blankets at the foot of each bed. He is bent, smaller, wizened; the cramps are gone. He turns from the window with its new, early morning light and lying down, for some reason, prefers the dark.



Then and Now

by John R. Guyton '73
Jon R. Polansky '74
Robert N. Weinreb '75

In a time of rapidly changing social values and student attitudes, it is remarkable to note that a 160-year-old tradition at Harvard Medical School is flourishing. From a low ebb in the fall of 1971, when there were only two active members, the Boylston Medical Society has once again become an integral part of undergraduate life. Interested students have been aided in this endeavor by the enthusiastic support of faculty presidents Pierce Gardner '61 and Dean of Students, Frederick Lane. Twelve student presentations last year are indicative of the strength of the Society, whose purpose as set out by the original endower, Ward Nicholas Boylston in 1811, remains "to promote emulation and enquiry among the students at the Medical School."

Present Activities

On the evening of a Boylston Society meeting, the student presenter and his faculty discussor dine at Vanderbilt Hall with members of the Society, the faculty president, and occasionally alumni. At dinner the conversation as well as the food is wholesome; spirited expositions, analyses, and polemics are reserved for the 7:30 meeting in the Vanderbilt Common Room. Attendance at the general meeting, which is open to the entire medical community, usually runs from 30 to 50 people. (Over 100 people came to hear a program on acupuncture given by Jim Frederickson '72 with Paul Dudley White '11 as faculty discussor). Enlivening the atmosphere are good beer, crackers, a selection of cheeses, and cigars. The student presentation is often accompanied by slides, movies, or judicious use of a blackboard. Following this, a faculty expert in the field adds his comments to validate or place in context what the student has said. Then the fun begins. An announcement may be made that individuals in the audience will be limited to one question plus one clarification at a time. Many different points of view, speculations, and counter arguments are raised with vigor, and the participants (few are simply listeners) finally leave the meeting highly

stimulated by the knowledge, ingenuity, and occasional balderdash of their classmates.

The goal of the Boylston Society last year was to have the programs be "as wide as the extent of curricular and extracurricular interests at HMS." Presentations on social medicine, which stirred spirited controversy, were Houston Johnson's '75 refutation of methadone treatment programs and advocacy of community development as cures to the social problem of heroin addiction (see HMAB, Jan-Feb 1973) and Henry Lerner's '75 dissertation on the need for certain forms of eugenics to alleviate the problem of man's deteriorating gene pool. An equally thought-provoking presentation was Larry Berger's '74 on the abuse of anti-personnel weapons and defoliants in Vietnam. John Guyton '73 would not take a stand on whether tight clinical control of diabetes can meaningfully affect the serious complications, but instead offered experimental evidence to show how an artificial beta cell under development might eliminate those complications. Slides of a trip to Shangri-La were featured when Steve Arnon '73 spoke on the legend of longevity in the Himalayan principality of Hunza. Two programs were concerned with the expression of the individual psyche; dreams and their Jungian interpretations by John Beary '73, and art therapy for emotionally disturbed children by Laura Alpern, wife of Lou '74. The social psychology of bullfighting was discussed by Dave Belcher '75.

One of the most important areas of emphasis in the Boylston Society schedule is the critical evaluation of medical education here at Harvard and elsewhere. Ed Benz '73 spoke on the merits of medical training in a non-academic setting, and Greg Gallico '73 discussed "The Itinerant Medical Student: Possibilities for Medical Education in Foreign Cities." A special activity of the Society has been to sponsor a student-wide selection of faculty members who have shown singular excellence in teaching over the

past three years. The winners of this award have been Harvey Goldman for 1969-70, Dan Federman '53 (Boylston Society member) for 1970-71, and Elio Raviola and Arnold Weinberg '56 (Boylston Society member) for 1972-73. At a special meeting last April, these professors expounded their ideas on good teaching and how it could be improved at Harvard Medical School. Their "faculty discussor" was Dean Robert H. Ebert.

Other Boylston speakers included: Jon Polansky '74 on a unifying hypothesis for the mechanism of the skeletal, dermatologic, and neurologic defects in hypothyroidism; Talmadge King '74 on the Health Careers Summer Program for disadvantaged high school students; Howard Freedman '73 (with a pilot talk of a possible Boylston series on leisure-time anti-atherosclerotic activities for physicians) on kayaking; and Jose Giron '74 on the true discoverer of the malaria vector — Carlos Finlay.

An Illustrious History

This account of Boylston Society activities would not be complete without a recollection of its illustrious past. The roll call of past members reads like a list of major contributors to American medicine from Harvard, including such names as Harvey Cushing, Francis W. Peabody, J. Englebert Dunphy, Leonard Wood, Harold C. Ernst, Arthur T. Hertig, Franz J. Ingelfinger, Herman L. Blumgart, John T. Edsall, Samuel A. Levine, and many others.

Boylston dissertations through the years (which, incidentally, can still be read in the rare book section of the Countway Library) have reflected the interests of the time. There was early discussion on such topics as, "Is the Use of the Stethoscope of Sufficient Practical Importance to be Recommended to Physicians Generally?" (1829), "The Comparative Merits of the Writings of Darwin and Brown" (1830), phrenology (1838), and the value of bloodletting and the theory of "Counter-irritation" (1866).

The future fields of interest of many men were foreshadowed by their Boylston presentations. Local and general anesthesia were discussed by future chief surgeons David Cheever (1900), John

Homans (1902), and William E. Ladd (1904). Francis D. Moore was interested in a historical perspective and spoke of "Civil War Surgery" (1939). Elliot P. Joslin talked about the "Pathology of Diabetes" (1863), future Nobel Prize winner, Thomas H. Weller, expounded upon the etiology of "Infectious Mononucleosis" (1940), and John P. Merrill considered "Renal Function Tests" (1945).

However, it has not been unusual for a member to present a topic that is only remotely related to his future professional endeavors. While members, future eminent surgeons John Homans, Jr. and Edward Churchill spoke on "Diabetes" (1860) and "Human Genetics" (1920), respectively, and Walter Cannon demonstrated that physiology was not always his primary interest when he discussed "Hypnotism in Medicine." "Dysmenorrhea" was of greater interest to William P. Murphy in 1920 than the investigation of pernicious anemia for which he and another Boylston Society member, George Minot, were later to win Nobel Prizes. And finally, Arnold Weinberg included a recipe for making wine in his talk on "Alcoholism Through the Ages" (1956).

An Evolving Structure

Since its inception as the first student medical society in America in 1811, the Boylston Society has evolved through several stages; but the student presentation, which lasts from 30 to 40 minutes, has always been the main event of a Society meeting. Such a presentation has been, and is today, the basic requirement for membership. In the past, attendance at Society meetings was restricted to members plus a limited number of guests; as already stated, the meetings, free beer and all, have been opened to any interested persons. At least one Boylston tradition has been criticized by some in the light of modern medical science — that is, the box of cigars brought to the meeting by the student presenter to be enjoyed by those attending. A few advocates of preventive medicine, with sensitive noses, regard the venerable custom as contrary to health.

The recent crisis of the Boylston Society already alluded to was not the first in its history. The following was once written by Benjamin Cotting:

In the winter of 1842-43, on the resignation of the President, I became (as Vice-President) the sole representative of the Boylston Medical Society of Harvard University. There were then no members and the Society's records could not be found! For several years the President had tried and failed to obtain the assistance of a sufficient number of students to carry on even a nominal meeting, and he had addressed the students of that year on the subject without avail. The prospect seemed gloomy enough, nevertheless the cause appeared worthy of another trial. By the aid of three or four acquaintances in the class of that session a new plan was adopted and the session closed with a score or more of interested and active members.

In 1972, as in 1842, it was felt that the revival of the Boylston Society might well depend upon re-evaluation of goals and the adoption of "a new plan." In past years, the Society often sought to function somewhat as a scholastic honor society. Members were elected on the basis of scholastic standing in addition to their "potential for stimulating contributions in dissertation and discussion." Only after being elected was the new member allowed and required to prepare a presentation. The "new plan" for the Boylston Society in 1973 implies a reversal of priorities inherent in the membership selection process. Rather than electing a member and then expecting him to devise a presentation, the Society simply regards the candidate for membership as a prospective speaker. The student submits the topic of his presentation to the program committee of the Society, whose job it is to assure a worthwhile schedule of meetings at biweekly intervals.

The ideal which we believe can sustain the Society (as stated in the Preamble to the 1951 Constitution) is "to provoke ... earnest inquiry into and free discussion of the traditions, the science, the art, and the practice of medicine." Thus, referring to the original stated purpose of 1811, we would make "enquiry" our primary goal and let "emulation" follow naturally. In so doing, we hope to put the Boylston Society on a firmer foundation, its strength to be derived from the same factor that proved to be a weakness in the recent past — namely, a discriminating audience of classmates and other members of the medical community. In the final analysis, the success of the Society will depend on a hearty interchange among all interested participants in the discussion. For the speaker, we would offer a formal outlet for ideas which he has found to be exciting and valid, and in addition, recognition for his considerable efforts in researching and preparing the topic. For the audience, there is the promise of an enjoyable evening and intellectual stimulation from a speaker whose energy and probing curiosity they may well wish to emulate.



Boylston Medal

Alumni are invited to help us formulate the evolving philosophy of the Boylston Medical Society by mailing their comments to: The Boylston Society, Box 011, Vanderbilt Hall, 107 Avenue Louis Pasteur, Boston, Mass. 02115. We would emphasize that the structure and rules of the Society are indeed in evolution, and our knowledge of the past strengths of the Society is perhaps incomplete. Should the cigars be saved? Alumni (including those who are not past members of the Society) are also warmly encouraged to attend any of the meetings of the Society, meet students, and participate in the discussions. Announcements of meetings are made at least two weeks in advance in the *Medical Area Focus*, or one may write to the above address.

The purpose of the Boylston Medical Society remains, as it has been since the inception of the Society, "to promote emulation and enquiry among the students at the Medical School of Harvard University." To insure its ability to carry out this purpose in the arena of present-day medical education, the forms of the Society are being somewhat modified. The future success of the Society, like its past success, will depend upon the desire of Harvard medical students to discover what's on and in the minds of their classmates.

